



VERIFICATION OF DEPENDENT DISABILITY

State Form 53388 (10-07)

INDIANA STATE PERSONNEL DEPARTMENT

Dependents on the State of Indiana Health, Dental, Vision, and Life plans are eligible for coverage until the end of the calendar year of their 19th birthday. Dependents may be eligible for coverage beyond that time if they are a disabled dependent.

Coverage may extend beyond the limiting age if the dependent is physically or mentally handicapped. Disabled dependent is defined as a dependent who, prior to age 19, is both:

- (1) Incapable of self-sustaining employment by reason of mental or physical disability, and
- (2) Is chiefly Dependent upon the employee for support and maintenance.

Such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists.

Note: The *following is not applicable to dependent life insurance coverage terms and condition*. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required.

Annual documentation from a physician is required each year after the child's attainment of the limiting age. You must complete this form every year within 120 days of the end of the plan year (December 31st) to continue coverage for each of your dependents if the above condition applies. The insurance carriers may require additional documentation including medical records showing the child's mental or physical disability and/or documentation showing the child is chiefly dependent upon the employee for support and maintenance.

Return this form to the State Personnel Department, Benefits Division; 402 West Washington Street, Room W-161; Indianapolis, IN 46204. You may also fax the form to the Benefits Division at 317-232-3011. Do not send this form directly to the insurance carrier(s). Please print clearly.

Name of employee _____

Employee ID: 10000

Name of dependent _____ Dependent DOB - -

Relationship to employee _____

Address of dependent _____

Names and Addresses of all Attending Physicians

1. _____
Name _____ Address _____ City _____ State _____ Zip Code _____

2. _____
Name _____ Address _____ City _____ State _____ Zip Code _____

ATTENDING PHYSICIAN STATEMENT

Diagnosis: _____

Date condition was first diagnosed _____

Is patient still under your care? Yes No

Frequency of treatments Monthly Weekly As Needed

How long has incapacity existed? _____

How long is incapacity expected to last? _____

Is patient capable of self-sustaining employment? Yes No

Comments _____

Signature of Attending Physician (*Required*)

Degree

Date

Printed Name of Physician

Address

City

State

Zip Code

AFFIRMATION

The undersigned insured person applies for continuation of disabled dependent's insurance. The insured person understands that continuation of coverage beyond the limiting age specified above is subject to approval by the insurance carriers and that continuous coverage is subject to written request having been made 120 days from the date the child attains the limiting age.

In making this application I understand that acceptance of continuation of coverage by the insurance carriers shall in no way affect regular termination provisions of the policy and that such disabled dependent's coverage shall terminate at such time that the insured person's coverage terminates. I hereby certify that the above statements are true to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I further authorize any physician, hospital organization, or insurance company to furnish any information required in regard to granting this application. A copy of this authorization shall be considered as valid as the original.

Signature of employee

Date